Maternity Care Program
Third Party Insurance Verification

To Whom It May Concern:

The following is a form seeking verification of health/medical insurance information – as required by Medicaid – for the following person. Please note that a release of information is included.

I, _____give permission for the _____
(patient's full name) (Insurance Company)
and/or Personnel Department of _____to release the following
(Work place of insurance holder)
information concerning my insurance coverage to

Patient Signature:_____ Date:_____

PATIENT INFORMATION

Name _____Date of Birth_____
Address_____
City_____County_____State_____
Zip_____SS#_____
Name and Address of Insurance Company _____
_____Phone_____
Policyholder's Name_____
Relationship to Patient_____
Policy # _____
Other Pertinent Data_____

TO BE COMPLETED BY INSURANCE COMPANY/PERSONNEL DEPARTMENT

Does the above named person have maternity coverage? Yes____No____

When did coverage begin? Month____Day____End Date: Month____Day____Year____

Is Pre-Certification required? Yes_____No_____

Additional Comments: _____

Signed: _____

Where should claims be filed? _____

_____

Telephone Verification: Yes____No____Date_____ Made by:_____

Please return form within 30 days to: _____
_____
If you have any questions, please call_____
(If possible, please include copy of policy booklet or pertinent sections. Thank you for your assistance)